EBD Health Insurance Enrollment Form:

The enrollment form is used for new employees, employees wanting to change health plans, or for mid-year enrollments allowed under Cafeteria Plan rules.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your request.

Section 1: Employee Information

Please provide the demographic information as requested.

- If you do not wish to enroll in health insurance, please complete section 1 of the enrollment form (except Primary Care Physician information) and check the box in the heading beside the words "I decline coverage for myself".
- Primary Care Physician (PCP) information is only required for members of the HMO or POS plans. Do not list a PCP if you are enrolling in either the PPO or HSA PPO plan.
- Health Plans no longer require a separate OB/GYN selection or referral, as long as the physician is an in-network doctor.
- NOTE: The PCP # can be found in the provider directory for the health insurance vendor you have selected. If you are unable to find the number, please contact the HR Manager for assistance.

Section 2: Dependent Coverage Information

Please provide complete information for each dependent you wish to enroll on your health plan.

- If you are married and/or have other dependents but do not wish to enroll them on this health plan, please indicate by checking the box beside the words "I decline coverage for my dependents" in the header of section 2.
- Notice that the first dependent section is for SPOUSE information only and subsequent blanks are for other dependents.
- If dependent(s) is/are age 19 or older, they must be a full-time student to continue on the insurance. Please indicate whether they are a full-time student. You must also submit a Student Verification Form to the HR Manager. This form can be obtained in the HR Office, or you may download a copy via EBD's website at www.arbenefits.org. You will find the form on the Benefits Library Link.
- If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents enrolled under your plan.
- If you have more dependents than space allows, please attach an additional sheet containing the required information.
- Each dependent can have a different PCP.

Section 3: I wish to Enroll in the Following Plan

Indicate the plan in which you want to enroll and at what level of coverage.

- Please check only ONE box in the HMO, POS, PPO, or HSA PPO section to indicate your plan selection. You and your dependents must be on the same plan.
- Also check the level of coverage you desire (Employee Only, Employee & Spouse, etc.) in section 3.

- If you select the HSA PPO plan, answer the questions below this section to aid in forms processing. If you select this plan, you must also complete a Payroll Deduction Authorization form, which is available in the HR Office.

Section 4: Other Medical Insurance

In order to aid coordination of benefits with other health plans you carry, please provide complete information in this section.

Section 5: To Be Completed by Agency

Do not complete this section. The HR Office will complete the information.

Section 6: Please Read Before Signing

Read entire section, then sign and date the form on the lines provided. It is recommended that you make a copy of this enrollment form for your records.

! Don't forget to return the form and any necessary attachments to the HR Manager to be processed.

STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 http://www.state.ar.us/dfa/ebd

State Employees
Enrollment Form

1. Employee Information: (please print) ❒ I decline coverage for myself				
Last Name	First Name	MI	Gender	❒ Married ❒ Single
Home Address	City	State	Zip Code	
Social Security #:	Date of Birth:	Home #:	Work #:	
†Primary Care Physician:	PCP #	Current patient?		

†Primary Care Physician lines are applicable for HMO and POS enrollees only, not PPO.

2. Dependent Coverage Information: ❒ I decline coverage for my dependents			
SPOUSE FIRST NAME	LAST NAME	MI	GENDER
Social Security #:	Date of Birth:		
†Primary Care Physician:	PCP #	Current patient?	
DEP 1* FIRST NAME	LAST NAME	MI	GENDER
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 2* FIRST NAME	LAST NAME	MI	GENDER
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	
DEP 3* FIRST NAME	LAST NAME	MI	GENDER
Social Security #:	Date of Birth:	Full time student?**	
†Primary Care Physician:	PCP #	Current patient?	

* Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.
**To be completed for dependents 19 and over only. Please submit proof of student status.

3. I Wish To Enroll In The Following Plan:			
H.M.O.	P.O.S.	P.P.O.	*H.S.A. P.P.O.
❒ Health Advantage ❒ NovaSys Health ❒ QualChoice/QCA	❒ Health Advantage ❒ NovaSys Health ❒ QualChoice/QCA	❒ Ark. Blue Cross & Blue Shield ❒ NovaSys Health	❒ *NovaSys Health (DataPath Salary Reduction Agreement form also required.)
❒ Employee Only	❒ Employee & Spouse	❒ Employee & Children	❒ Family

*As of the effective date of this plan year, are you eligible to participate in a Health Savings Account? ❒ Yes ❒ No
For clarification see www.ArkansasHSA.com or call 1-877-685-0655.

4. Other Medical Insurance:

1) Will you or any of your family members be continuing any other health insurance? ❒ Yes ❒ No
2) If Yes, what type of coverage? ❒ Medical ❒ Medicare, HIC # _____
If Medicare: Part A Effective Date / / or Part B Eff Date / /
If Medicare: Reason for Coverage: ❒ Over age 65 ❒ Disabled ❒ Kidney Disease
Please make sure EBD and your carrier has a copy of your Medicare card.
If you answered Yes to the question above, complete below: (Use additional paper if necessary)

Covered Person's Name	Coverage Type (single/family)	Effective Date	Policy Holder's Employer

Name/Address/Phone/Policy # of Health Ins Co.:

5. To Be Completed By Agency:

Agency #:	Name of Agency	
Employee #:	Hire Date:	Effective Date of Coverage:
If employee is transferring from another agency, please provide name:		

Insurance Representative Signature: _____

Print Name: _____

6. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer and the employer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee's Signature: _____ **Date:** _____